PUT PREVENTION INTO PRACTICE IMPLEMENTATION MANUAL

TABLE OF CONTENTS

FORWARD

The NEHC Technical Manual TM 6100.98-3 (September 1998) "Put Prevention Into Practice (PPIP) Implementation Manual" has been developed to assist and guide the development and implementation of PPIP into your Command's MTF/DTF and their branch clinics.

This is the first edition of the PPIP Implementation Manual. Our attempt was to develop a comprehensive manual that would aid in the implementation of PPIP, the roles, responsibilities and necessary resources. We realize, however, that no matter how hard you try, there is always room for improvement. What is clear to us, may not be clear to everyone. In the spirit of continuous quality improvement, we seek out your comments, suggestions and corrections. Please submit these to:

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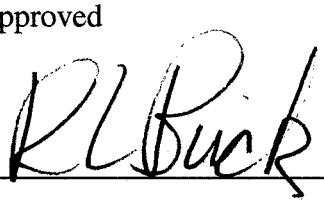
This manual was developed by Bill Calvert, MS, MPH, MBA, Acting PPIP Program Manager with the assistance of Mark A.D. Long, Ed.D, of the PPIP Team. We would like to acknowledge NEHC reviewers for their support and input; CAPT R.L. Brawley, former Director of Health Promotion and Medical Management, CDR Deborah McKay, Deputy Director, and all the NEHC Health Promotion staff. Special thanks are extended to Thomas Pittman, BSN, PPIP Program Manager, USAF. The Air Force has been instrumental in the development of the HEAR Survey and DD Form 2766. Tom provided thoughtful review of this manual and we are indeed appreciative. Finally, we would like to acknowledge Nancy Von Tersch, former PPIP Program Manager, Janet Mano, Health Promotion Coordinator, NH Bremerton and Genice Beightol, Health Promotion Coordinator, NH Camp Lejuene, two of our PPIP Demonstration Sites. They have been involved with PPIP for several years and lead the Navy with its implementation.

We hope this manual will live up to everyone's expectations! Good luck to you as you journey down the path of health and wellness.

Reviewed and Approved



R.L. Buck
Commanding Officer

INTRODUCTION

WHAT IS PUT PREVENTION INTO PRACTICE (PPIP)

Put Prevention Into Practice (PPIP) is a national, research-based public-private program to increase the appropriate use of clinical preventive services (screening, immunizations, and counseling).

The U.S. Department of Health and Human Services' Office of Disease Prevention and Health Promotion (ODPHP) developed PPIP. In 1998, management of the project was transferred to the Agency for Health Care Policy and Research (AHCPR). PPIP is now a part of AHCPR's integrated program in clinical prevention, which includes support for the U.S. Preventive Services Task Force (USPSTF) and ongoing research on the costs, outcomes, and quality of preventive care.

HOW PUT PREVENTION INTO PRACTICE (PPIP) WAS DEVELOPED

The Office of Disease Prevention and Health Promotion (ODPHP) launched PPIP in August 1994 as a way to improve implementation of the recommendations of the USPSTF and to overcome many of the barriers to the effective delivery of clinical preventive services. Such barriers may include:

- Patient barriers: Lack of knowledge or motivation, anxiety about procedures and possible results, inconvenience, costs, and unrealistic expectations about benefits of some services (this is related to the overuse of some preventive services).

- Clinician barriers: Lack of prevention training, lack of "self-efficacy" (confidence that preventive interventions can make a difference), lack of time in face of competing demands, efficient use of corpsmen, nurses and support staff, confusion due to conflicting recommendations, lack of knowledge about new tests, inadequate reimbursement for prevention, liability concerns and patient demand (this is related to the overuse of some preventive services).

- Office barriers: Lack of knowledge, motivation, readiness for change, or support among office staff, clinical setting focused upon illness rather than on prevention, and inadequate office systems for tracking delivery of and follow-up for preventive services.

The original PPIP materials were based on research-tested interventions for improving the delivery of preventive services in primary care settings, and on focus group testing with clinicians, office staff, and patients. Both the 1994 and 1998 versions were developed with the cooperation of numerous public and private institutions, including the 31 members of the National Coordinating Committee on Clinical Preventive Services (NCCCPS) , federal liaisons to the NCCCPS, other federal agency experts, and many other contributors from academic institutions, state departments of health, professional groups, and voluntary organizations.

WHY PUT PREVENTION INTO PRACTICE IS NEEDED

The vast majority of premature death and disability in the United States results from preventable factors and causes. The U.S. Preventive Services Task Force (USPSTF) concluded that there was strong evidence that a variety of clinical preventive services can prevent some of the leading causes of death or disability. At the same time, research also shows that clinicians do not provide all the services their patients need, and that patients request services that have been found to be ineffective or to even have unproven benefits. Examples of the value and need for PPIP follow.

- A study published in the March 15, 1998, issue of the journal *Cancer* by the National Cancer Institute, Centers for Disease Control and Prevention (CDC), and American Cancer Society reported that cancer incidence and death rates for all cancers combined and for most of the top 10 cancer sites declined between 1990 and 1995. The findings demonstrate that prevention does work; according to the authors, decreasing mortality from breast cancer in white women most likely is a reflection of the increasingly widespread diffusion of breast cancer screening into routine medical care. On the other hand, the findings also show there is still much work to be done; the study notes, for example, that for black women, breast cancer incidence continues to increase, mortality trends are not decreasing, and that breast cancer is diagnosed at later stages in black women than in white women.

- An AHCPR-supported study published in the May 1997 issue of *Preventive Medicine* found that low-socioeconomic-status patients are substantially less likely to be up-to-date on immunizations and screening tests (with the exception of blood pressure readings) than other patients.

- AHCPR-supported research published in the February 25, 1998, *Journal of the American Medical Association* (JAMA) by researchers at Massachusetts General Hospital and Harvard Medical School showed that American physicians are missing many opportunities to help their patients quit smoking. For example, in 1995, physicians in the study counseled smokers to quit at only 21 percent of office visits. In another AHCPR-supported study (published in the December, 3, 1997, JAMA), researchers concluded that if doctors advised each of their patients who smoked to quit, an additional 1.7 million people would quit smoking each year.

- CDC reported in February 1998 that a high proportion of office visits to obstetricians or gynecologists, internists, family or general practitioners, cardiologists, and other specialists in 1995 did not include counseling for the prevention of cardiovascular disease.

- In 1997, the National Committee for Quality Assurance released a report showing a wide range of performance by health maintenance organizations and other managed care plans nationwide in the delivery of preventive services and other health care. For example, the report shows that in 1996, 81 percent of New England children under age 2 in managed care plans received appropriate immunizations, but in the Mountain region the rate was only 59 percent. Plans in the Mid-Atlantic region reported mammography screening ranging from 30 percent to 80 percent. Also, patients in some plans received advice to quit smoking as infrequently as 30 percent of the time, and in other plans as often as 85 percent of the time.

- According to the February 1991 issue of the journal *American Family Physician*, studies have generally shown that physicians perform, on the average, only 20 percent to 60 percent of the tests and procedures recommended by major health organizations.

PARTICIPATING ORGANIZATIONS

Since the PPIP materials were first made available in 1994, private-sector companies, medical societies, academia, and federal, state, and local government agencies have answered the call to action and have incorporated them into national, regional, and local prevention-oriented clinical and educational activities. The materials are readily tailored to users' specific needs and can be used in a diverse range of settings. Some examples include:

Texas Department of Health: In 1994, the Texas Department of Health (TDH) made improving the delivery of preventive services a priority and established support systems throughout the State to encourage the implementation of PPIP. Specially trained registered nurses are stationed around the State in an effort to provide one-on-one instruction in the use of materials and PPIP implementation. TDH also provided start-up funds to primary care sites Statewide, including several family practice residency programs, which have been successful change agents in implementing PPIP. As the project evolved, TDH developed companion pieces including a 20-item comprehensive health risk assessment, a 10-item targeted risk assessment, and a self-administered risk assessment, which is currently being pilot-tested in a rural health department. TDH also has plans to customize the Personal Health Guide to focus on the specific health needs of citizens in Texas.

STEP-UP: Clinical Trial PPIP tools are part of the STEP-UP (Study To Enhance Prevention by Understanding Practice) clinical trial. STEP-UP, launched in 1997, involves 80 family practices and clinics across Northeast Ohio in urban, rural, and suburban areas, including large Amish populations. The STEP-UP study evaluates a preventive service delivery intervention that is tailored to the unique characteristics of each practice. A nurse facilitator is assigned to each practice to identify special prevention-oriented needs of the practice population, such as immunizations, screenings, and counseling. The STEP-UP manual provides tools for clinicians to use as-is or modify. PPIP materials included in the STEP-UP manual include adult and child preventive care flow sheets, child immunization flow sheets, posters, and patient reminder postcards. The STEP-UP trial plans to continue using PPIP tools because they can easily be adapted to clinicians' needs as they work to enhance the delivery of preventive services to local patient populations.

Department of Defense: A Military Health System (MHS) joint task force of multidisciplinary health care professionals has developed a plan for health promotion and wellness, clinical preventive services (CPS), and self-care that includes the training of staff and education of all beneficiaries about health and fitness. This plan will be implemented at selected Service Model Sites, beginning April 1998, and will extend beyond the walls of the Military Treatment Facility (MTF) and the Dental Treatment Facility (DTF) to worksite and community-based health promotion and wellness programs that include line and community partnerships. Monitoring and

evaluation of the Model Site programs will be ongoing. Lessons learned at these sites shall be shared throughout the MHS and used to expand PPIP to all MTFs and DTFs. The designated Service Model Sites are:

Army:	William Beaumont Army Medical Center, Fort Bliss Texas
	Tripler Army Medical Center, Honolulu, Hawaii
Navy:	Naval Hospital Camp LeJeune, North Carolina
	Naval Hospital Jacksonville, Florida
	Naval Hospital Bremerton, Washington
Air Force:	Brooks AFB Clinic, San Antonio, Texas

MILITARY HEALTH SYSTEM AND PPIP

INTRODUCTION

In October 1994, a Tri-Service "Put Prevention Into Practice Implementation Conference" was held. The goals of the meeting were to:

- Demonstrate the need for PPIP in the Military Health System (MHS)
- Seek the Program's support at the highest levels of DoD and the Armed Services' medical leadership
- Review the scientific basis for PPIP's development and effectiveness
- Identify barriers to delivering clinical preventive services within MHS
- Develop strategies among the various medical commanders, providers, nurses, health promotion officers, public health officers, medical administrators, and others who attended the meeting
- Begin developing implementation plans for TRICARE regions and medical treatment facilities (MTFs)

In January 1997, the MHS Strategic Planning Workgroup recommended a breakthrough to dramatically increase the focus of the MHS on health and fitness. One of the objectives was to develop a plan to train staff and educate beneficiaries in health and fitness. The Workgroup decided that an overarching plan for the MHS should be drafted. This issue was discussed at the April 15, 1997 MHS Workgroup meeting that recommended that representatives of the U.S. Army Center for Health Promotion and Preventive Medicine (CHPPM), the Air Force Medical Operations Agency (AFMOA), and the Navy Environmental Health Center (NEHC) develop a Tri-Service Plan. This plan was requested, in a 14 May 1997 memorandum, from the Assistant Secretary of Defense for Health Affairs.

A plan was developed, entitled, "***Plan for Implementation of Put Prevention Into Practice (PPIP) and Training Staff and Educating Beneficiaries in Health and Fitness***". This document is available in Appendix A. This valuable document is the cornerstone for PPIP throughout MHS. The core of this plan is the prevention component that encompasses health promotion and wellness, clinical preventive services, self care, and all components of PPIP. This is only the beginning. To accomplish the implementation of preventive health care throughout MHS and DoD, prevention must extend beyond the wall of the MTF/DTF and out into the workplace and the community. This document will assist you to implement PPIP while encouraging and guiding your efforts to develop a worksite and community health promotion program.

GOAL OF PPIP IN THE MILITARY HEALTH SYSTEM

The Goal of implementing PPIP in the MHS, is to use a nationally developed and recognized program, to increase the delivery of clinical preventive services (CPS), as described by the U.S. Preventive Services Task Force and in accordance with established policy by the Office of the Assistant Secretary of Defense Health Affairs (DoD(HA)) and the Bureau of Medicine and Surgery (BUMED). MHS implementation of PPIP supports the transformation of healthcare delivery focus from treatment of illness and injuries to health promotion and wellness, prevention of injures, and improving the health of TRICARE PRIME enrollees. We will integrate targeted clinical preventive services for all active duty and TRICARE Prime beneficiaries within our Navy Medical and Dental Treatment Facilities (MTFs & DTFs) and their clinics, ashore and/or afloat, using a systematic population based approach. Using the DoD(HA) PPIP implementation plan will encourage a systems approach to prevention and wellness that will reach all of our population.

OBJECTIVES

The PPIP program supports the MHS and Navy strategic plans. The program links individual education and responsibility in attaining a state of good health, with direct access to age and sex appropriate preventive services. For PPIP to succeed, the plan, organization, and implementation must be based on both the population and the individual. This "two-pronged" approach is best accomplished by the seamless integration of individual, worksite and community based health promotion and wellness programs and health education that **complement** and **augment** clinical preventive services (CPS) provided for individuals in MTFs and DTFs. CPS, as part of PPIP includes:

1. Increasing the delivery of immunizations and chemoprophylaxis
2. Screening for pre-clinical disease, and
3. Counseling to motivate health behavior change.

MHS STRATEGIC PLAN

The Military Health System (MHS) Strategic Plan emphasizes wellness versus illness. MHS is positioned to be the benchmark health care delivery system of the 21st Century, emphasizing readiness, **health promotion**, and managed care for all Armed Forces personnel, their families and others eligible for care. This strategic plan demonstrates the commitment of our Tri-Service teams to face, together, the challenges inherent in our changing roles and missions, as well as those being brought on by revolutionary changes within the health care community. These joint efforts support and promote collaboration, team building, and reengineering across the continuum to enhance quality, curb costs, and ensure access to all entrusted to our care.

The MHS will be the world's best integrated health system. The MHS spans the continuum of health care from the operational and readiness mission to the delivery of the health benefit. To accomplish this, we must optimize use of the three Service medical departments to meet the

MHS mission. Only in this way can we be health- and fitness-focused and responsive to customer needs where cost, quality, and access are paramount. Strategies to achieve this are to communicate the TRICARE benefit so our eligible beneficiaries will be educated and responsible consumers and to **promote prevention and wellness as the foundation of the system**.

The MHS Plan includes a goal for Healthy Communities. Strategies for this goal include:

- Utilization of comprehensive, population-based, medical information systems as a foundation for evidence-based disease prevention and health decision making, and
- Sustaining the prevention culture at home and abroad, in peace and war.

The MHS Strategic Plan is available from the DoD(HA) Internet site of: http://www.ha.osd.mil/ppc/strat_ov.html. Those without Internet access can request it from: Planning and External Affairs, Office of the Assistant Secretary of Defense (Health Affairs), 1200 Defense Pentagon, Washington, DC 20301-1200, or via e-mail at: stratplan@ha.osd.mil.

DoD POLICY FOR PUT PREVENTION INTO PRACTICE

Health Affairs Policy Memorandum HA 980027 (Appendix B) prescribes policy for the staged implementation of PPIP in accordance with the Military Health System (MHS) Strategic Plan and requires services to develop strategies and systems to successfully implement PPIP at all MTFs and DTFs worldwide. Facilities already implementing PPIP are encouraged to proceed with their efforts. This policy applies to all military hospitals and clinics by April 1999:

(a) Establish staffing and resourcing structures for primary care sufficient to provide acute care, chronic care, and clinical preventive services. Establish staffing and resourcing structures for health promotion and wellness to provide individual workplace, and community based health promotion and health education.

(b) Administer the age appropriate HEAR (Health Enrollment Assessment Review) annually to all TRICARE PRIME (including Active Duty) beneficiaries.

(c) Implement aggressive campaigns to screen immunization status at every visit and provide age appropriate immunization services due to all infants, children, adolescents, and adults.

(d) Ensure age and sex appropriate clinical preventive screenings and other services are provided through the TRICARE PRIME Clinical Services Benefit. Prevention and health promotion counseling shall be provided at every medical and dental patient encounter, particularly in primary care settings acute care, and emergency rooms.

(e) Document clinical preventive services and prevention or health promotion counseling delivered in medical records. The MHS prevention flowsheet must be used in every outpatient medical record for TRICARE PRIME beneficiaries.

(f) Provide the PPIP publication "Clinicians Handbook of Preventive Services" to all providers and support staff members in primary care settings at medical and dental treatment facilities.

Prevention and health promotion performance measurements as required by the MHS shall be accomplished through evaluation instruments such as HEDIS, HEAR, the DoD Annual Beneficiary Survey, and the Tri-annual DoD Survey of Health Related Behaviors Among Military Personnel.

The remainder of this implementation manual has been organized to coincide with the structure of the DoD and the forthcoming BUMED policies. Items (a) through (f) of the DoD Policy represent subsequent sections of this manual. Each item is repeated as the first paragraph/sentence for each respective section. Item (a) has been separated into two sections: "Staff and Resourcing Structures" and "Health Promotion and Health Education". Item (f) has been expanded into two sections: "Essential Resources" and "Other Resources, References Books and Materials".

A BUMED Policy for Putting Prevention Into Practice in currently being developed. In addition to the DoD Policy, the BUMED Policy will include specific process and outcome measurements that must be implemented in all MTFs, DTFs, and their clinics. These measurements are covered in the section "Monitoring and Evaluation". Coinciding Process and Outcome Objectives will be also listed at the start of each section with text highlighted, where appropriate, throughout the manual.

STAFF AND RESOURCING STRUCTURES

POLICY: Each MTF and DTF must establish staffing and resourcing structures for primary care sufficient to provide acute care, chronic care, and clinical preventive services.

PROCESS OUTCOMES REQUIRED FROM POLICY:

1. Established ownership of prevention oversight, designated in writing.
2. Prevention Committee established, and members, designated in writing.
3. PPIP Coordinator appointed, with 100% of time dedicated, designated in writing.
4. PPIP Coordinator has dedicated computer with Internet access.
5. PPIP Provider Champion appointed, with 25% of time dedicated, designated in writing.
6. Develop a local PPIP implementation plan in writing.
7. Identify both process and outcome measurements as outlined by the MHS Plan.

Implementation of PPIP at your MTF/DTF, begins with the MTF/DTF Commanding Officer (CO) or Officer in Charge (OIC). There are important roles that must be fulfilled. The CO or OIC should designate "ownership" for PPIP. The most likely person will be the Director for Clinical Medical Services. A list of staff, structure and responsibilities follow:

MTF/DTF COMMANDING OFFICER

The MTF/DTF Commanding Officer, or OIC, ensures the integration of PPIP throughout the facility. The Commanding Officer is responsible for:

1. **Designating ownership** of prevention oversight to oversee the overall prevention program and initiatives that ensure beneficiaries are given timely clinical preventive services.

2. **Issue and maintains letters of appointment** for the PPIP coordinator, PPIP provider champion, and members of the Prevention Committee. MTF/DTF responsibilities are further detailed in MTF/DTF Prevention Committee, below.

3. Provides appropriate medical staff, facilities, equipment, and funds to conduct the PPIP program and ensures an organization-wide mechanism for verifying MTF/DTF personnel compliance with program requirements.

4. Ensures communication of the following information on the current PPIP coordinator and PPIP provider champion to the NEHC PPIP Program Manager:
   - Full name
   - Rank
   - Position (i.e., PPIP coordinator, provider champion, etc.)
   - Corps affiliation
   - Organization
   - Office symbol

- Mailing address
- DSN and commercial duty phone
- DSN and commercial fax number
- E-mail address

PPIP COORDINATOR

The PPIP coordinator should be a professional provider (R.N., M.D., P.A., nurse practitioner, or Independent Duty Corpsman (IDC)) trained or experienced in disease prevention and health promotion. The PPIP coordinator **should not** serve as either the health promotion manager or the Prevention Committee chairperson. The PPIP Coordinator must be **dedicated 100%** to PPIP activities.

The PPIP Coordinator should have the following responsibilities:

1. Advocates prevention and wellness.
2. Serves as a point of contact for local PPIP activities.
3. **Develop PPIP Implementation Plan** in coordination with Prevention Chairperson and Committee.
4. Ensures that the organization-wide prevention program is continuously evolving.
5. Coordinates prevention education and skills training sessions for staff and beneficiaries.
6. Oversees ordering PPIP office materials; DD Form 2766, Adult Preventive and Chronic Care Flowsheet; educational materials; etc.
7. Establishes and maintains the PPIP budget. Works with the resource manager to respond to budget-status inquiries.
8. Is a resource to the MTF/DTF in developing evaluation criteria for clinical and occupational preventive outcomes, meeting accreditation standards for health care documentation, etc.
9. **Identifies and implements both process and outcome evaluation activities as part of the BUMED instruction and MHS Plan.**
10. Assesses and improves the quality of preventive services by using process/outcome evaluation measurements.
11. Attends PPIP video/telephone conferences.
12. **Has dedicated computer with Internet access**, to use as a prevention research tool and to review the PPIP homepage (www-nehc.med.navy.mil) for program updates and new materials of interest.

PPIP PROVIDER CHAMPION

The PPIP provider champion should be a primary care physician able to **devote 25 percent** of his or her time (e.g., one full day or two half-days, as needed) to PPIP activities such as training other providers, community education, working with PPIP coordinator, etc.

The PPIP Provider Champion should have the following responsibilities:

1. Advocates prevention and wellness.
2. Works with providers to ensure that patients receive required prevention services.
3. Provides an initial orientation and ongoing in-service to providers.
4. Works with the PPIP coordinator in coordinating prevention-education and skills-training sessions for staff and beneficiaries.
5. Provides community education.
6. Works with Quality Improvement/Process Improvement personnel in the development of quality measures and a performance feedback plan.
7. Assesses and improves the quality of preventive services by using process/outcome evaluation measurements.
8. Develops and coordinates performance feedback plan for clinical staff.
9. Reviews the PPIP homepage (www-nehc.med.navy.mil)) for program updates and new materials of interest.
10. Attends PPIP video/telephone conferences.

MTF/DTF PREVENTION COMMITTEE

The MTF/DTF Commanding Officer, or OIC, will appoint a Prevention Committee chairperson from the MTF senior leadership and ensure establishment of a Prevention Committee charter. Further, the MTF/DTF CO, or OIC, selects Prevention Committee members from key medical-group personnel, to provide oversight for the integration of clinical prevention activities. The prevention committee assists with the standardization of patient risk assessment, provider and staff education, patient education, documentation, and outcome evaluation. This committee should develop appropriate and effective clinical preventive services by using population-based medicine.

Recommended committee membership follows:

1. PPIP Coordinator
2. PPIP Provider Champion
3. Medical Officer
4. Dental Officer
5. Nursing Officer
6. Primary Care Provider
7. Medical Technician
8. Comptroller
9. Health Promotion Coordinator
10. TRICARE Representative
11. Health Care/Utilization Manager Coordinator

12. Mental health personnel (Clinical Psychologist, social worker, or Psychiatrist)
13. Senior Enlisted

The MTF/DTF CO, or OIC, further ensures that the MTF/DTF Executive Committee reviews Prevention Committee minutes and that the MTF/DTF Executive Committee reviews relevant prevention information on the MTF/DTF-specific performance measurement tool, DoD Report Card, Health Plan Employer Data Information Set (HEDIS), Joint Commission on Accreditation of Healthcare Organizations (JCAHO) inspection, and Health Services Inspection (HSI).

The PPIP Prevention Committee members are responsible for the following:

1. Participate in developing prevention processes and policies for the health care system, considering especially the integration and collaboration of internal administrative, clinical, and occupational health policies.
2. Review and approve PPIP Implementation Plan and prevention proposals.
3. Integrates PPIP into command Process Improvement (or Quality Improvement) Plan.
4. Advocate prevention programs to subordinates and co-workers.
5. Make recommendations to the Executive Committee for the use of prevention funds.

PREVENTION COMMITTEE CHAIRPERSON

The Prevention Committee Chairperson is responsible for the following:

1. Oversees activities of the PPIP program.
2. Ensures the development and maintenance of an MTF/DTF PPIP operating instruction.
3. Provides leadership and consultative services to departments and agencies or sections within the organization, to achieve regulatory, accreditation, and organizational compliance, and performance improvement in prevention activities.
4. Directs the prevention training and education of organizational leaders.
5. Coordinates the dissemination of prevention performance-improvement information within the organization, including basic statistical analysis and comparative processes.
6. Oversees the PPIP Implementation Plan and prevention plan process.
7. Participates in problem assessment, solution recommendations, implementation, and follow-up activities regarding the quality of preventive services, including tracking abnormal results.
8. Submits minutes of the Prevention Committee and results of performance-measurement tools to the MTF/DTF Executive Committee for review.
9. Attends PPIP video/telephone conferences.

PREVENTION MARKETING TEAM

A Prevention Marketing team, while not a required committee of DoD and BUMED policy, can assist with implementing and sustaining PPIP efforts. The team:

1. Advocates prevention and wellness.
2. Should consist of Public Affairs Officer.
3. As its main goal, promotes prevention and PPIP as a tool.
4. Each MTF is unique in its delivery of health care and the population it serves. The team should design marketing strategies to capitalize on this uniqueness. Areas for consideration are:
    - Conducting a media campaign (video, TV, stickers, radio, computers, web pagers, T-shirts, posters, etc.)
    - Using "Meet one, teach one" (word of mouth)
    - Using discharge teaching (inpatient)
    - Using PPIP materials routinely
    - Becoming part of newcomers' orientation
    - Initiating catchy phrases or slogans
    - Focusing on the cost of care vs. the cost of prevention
    - Promoting the benefits of staying healthy

PROVIDERS

Everyone is important in the delivery of preventive services. Equally, it is important to use every patient encounter as an opportunity for preventive care. Many patients, particularly young adults, visit their provider or clinic for acute treatment but rarely come in specifically for preventive care. Other, often older, patients with chronic medical problems visit regularly but do not schedule preventive care appointments. In order to take advantage of acute and chronic care visits as opportunities to deliver preventive care, a tracking and prompting system should be in place to allow the clinician to determine quickly a patient's need for preventive care.

All Providers will:

1. Advocate prevention and wellness.
2. Incorporate preventive interventions into each patient encounter, using the Tricare Prime Benefit, and the *Clinician's Handbook of Clinical Preventive Services* or the US Preventive Services Task Force's (USPSTF) *Guide to Clinical Preventive Services* as a reference.
    - Counsel patients (including providing printed media) on health and wellness/preventive medicine topics, based on identified health and occupational risks, and the patient's desire to change associated beliefs and behaviors.
    - Document health and wellness/preventive counseling, referrals, and prescriptions on SF 600, **Chronological Record of Medical Care**, using the "SOAPP" note format (where the second "P" indicates prevention).

- Review patient's risk behaviors on DD Form 2766. This documentation is based on a review of the patient's record, HEAR (or other health risk assessment, if HEAR is not available), clinical findings, occupational risks, and interviews.
- Ensure that patients receive appropriate screenings or exams at the frequencies specified on the DD Form 2766.
- Refer patients with documented health risks to appropriate health-education programs (Health Promotion, Wellness Centers, public health, nutrition, family advocacy, etc.) for counseling, support, and follow-up.

3. Assess and improve the quality of preventive services by using process/outcome evaluation measurements.
4. Develop and advocate prevention initiative programs.

HEALTH EDUCATOR

A full-time health educator in the primary care clinics (i.e., family practice, OB-GYN, primary care) is critical to providing clinical and occupational preventive services to beneficiaries. The are responsible for the following:

1. Advocates prevention and wellness.
2. Provides briefings and literature to patients, based on specific issues identified by providers.
3. Incorporates preventive interventions into each patient encounter, using the Tricare Prime Benefit and the *Clinician's Handbook of Clinical Preventive Services* or the *Guide to Clinical Preventive Services* as a reference.
    - Counsels patients (including providing printed media) on health and wellness/preventive medicine topics, based on identified health and occupational risks, and the patient's desire to change associated beliefs and behaviors.
    - Documents health and wellness/preventive counseling and referrals on SF 600, using the "SOAPP" note format (where the second "P" indicates prevention).
    - Documents the identification and review of patient risk behaviors on DD Form 2766. This documentation is based on a review of the patient's record, HEAR (or other health risk assessment, if HEAR is not available), clinical findings, occupational risks, and interviews.
    - Ensures that patients receive appropriate screenings or exams at the frequencies specified on the DD Form 2766.
    - Refers patients with documented health risks to appropriate health education programs (Health Promotion, Wellness Centers, public health, nutritional medicine, New Parent Support Team, etc.) for counseling, support, and follow-up.
4. Assesses and improves the quality of preventive services by using process/outcome evaluation measurements.
5. Develops and advocates prevention initiative programs.

MTF STAFF COLLABORATION

A coordinated, facility-wide approach to improving population health requires an intensive, integrated, and collaborative systems approach by all staff. Although not all disciplines may be centrally located, every effort must be made to communicate and collaborate in planning and carrying out prevention programs and activities. As part of this collaboration staff should:

1. Advocate prevention and wellness.
2. Order and maintain sufficient quantities of health and wellness/preventive pamphlets in exam rooms and reception areas
3. Ensure that each credentialed provider has and understands how to use the *Clinician's Handbook of Preventive Services*.
4. Prior to each patient visit, ensure a DD Form 2766 is present in the patient's medical record.
5. Review and update the DD Form 2766, based on information obtained from the health record.
6. Ensure that patients receive appropriate counseling and/or screenings and exams at the frequencies specified on the DD Form 2766.
7. Provide health and wellness/preventive support to patients, as self-referred, directed, or recommended.
8. Assess and improve the quality of preventive services by using process/outcome evaluation measurements.
9. Develop, advocate, and/or manage prevention initiative programs.

PERSONNEL ISSUES

Additional staff may be needed to implement PPIP. There are several ways you can establish positions, either through your command's Human Resource Office (HRO), through permanent or temporary positions, or through contracts with an outside agency. You should check with your commands comptroller, contracting officer, and/or HRO representative to determine your command's protocol and process as well as discuss the pros and cons of each method.

CONTRACTS THAT CROSS FISCAL YEARS

Federal Acquisition Regulation (FAR) 37.106 states that contracts for services that are funded by annual appropriations may not extend beyond the end of the fiscal year of that appropriation, except when authorized by law. Section 801 of the FY 1998 Defense Authorization Act recently revised 10 U.S.C. 2410a to allow Military Departments to enter into contracts for procurement of services for a period that begins in one fiscal year and ends in the next, using funds made available for one year, if (without regard to any option to extend the period of the contract) the contract period does not exceed one year. Although the revisions implementing Section 801 are not currently incorporated in the FAR, you may begin using the new statutory authority. As noted above, the FAR already states that contracts may cross fiscal years when statutory authority exists for them to do so, and Section 801 provides such authority even though it is not yet cited in the FAR.

Revisions to the DFARS to require annual reporting (at least for FY 1998 and 1999) concerning contacts awarded using the Section 801 authority are also in process. Please ensure your activities have appropriate mechanisms in place for capturing and reporting this information if they make awards using the Section 801 authority.

The use of Section 801 is confirmed in a 2 JUN 1998 Memorandum from Commander, Naval Supply Systems Command, subject "Authority to Award Severable Service Contracts That Cross Fiscal Years".

Your local comptroller can further advise you on these regulations.

POSITION DESCRIPTION AND STATEMENT OF WORK

An essential component to hire positions to support PPIP activities are position descriptions and statements of work. In Appendix C are samples of PPIP Coordinators, Health Educators, and other positions which have been hired by the Navy's three demonstration sites.

HEALTH PROMOTION AND HEALTH EDUCATION

POLICY Staffing and resourcing structures for health promotion and wellness must be established to provide individual workplace, and community based health promotion and health education.

PROCESS OUTCOMES REQUIRED FROM POLICY:

1. PPIP Training completed for 75% of primary care staff.
2. Document PPIP training provided to all staff.
3. PPIP educational materials provided to 75% of TRICARE Prime patients seen at medical facility.
4. PPIP Clinician's Handbook provided to 75% of primary care staff.
5. Performance feedback to providers completed monthly.
6. Reminder system established.
7. Implement a comprehensive worksite health promotion program at all MTFs and DTFs.
8. Ensure all command components work toward the goal of building a healthy community.

PROVIDER EDUCATION

A health care staff member is anyone the patient encounters in the health care system. Training and support are essential for everyone who works with patients, from the person who answers the telephone for an appointment, to the person who fills prescriptions. All of these staff need PPIP education and a "prevention" attitude. PPIP represents a paradigm shift within the Military Health System (MHS). All health care providers need preventive medicine training in order to understand this new way of doing business. The *Guide to Clinical Preventive Services* provides a comprehensive review of screening, counseling, and other preventive services, with uniform recommendations for screening interventions. Providers should examine the appropriate data and determine whether to use a particular intervention in a specific situation. PPIP must be integrated into the system, so that it is both rewarding and reinforcing. Providers should want to practice prevention. Everyone in Navy Medicine must promote prevention, not just providers.

Concerted efforts will be required to change provider behavior toward improving Clinical Preventive Services (CPS) delivery. Multiple concurrent methods will be the most effective in producing behavior change. These methods include:

1. **Provider education and skills training** (especially for counseling techniques and behavior modification strategies) through clinical guidelines, continuing medical education, modeling by leadership, and academic detailing.
2. **Ongoing performance feedback** (compare provider delivery of CPS with peers and internal/external standards). Performance Feedback on a regular monthly basis to primary care providers and staff will be accomplished by medical managers (PCMs) reviewing individual performance measures with providers. Measures include compliance with forms completed in the patients outpatient medical records, adherence to prevention recommendations, percent of individuals who accept offered interventions, success rate of various other program interventions. The Quality Improvement Personnel

for the command will track performance via chart audits, and coordinated activities by the designated command's PPIP coordinator.

3. **Prompting to provide CPS at the time of every patient visit** (e.g., chart flowsheets, reminder stickers, and computerized records). A Patient Routing Slip and Instructions is provided in APPENDIX G as an example that you may utilize.
4. Administrative rules that decrease barriers to delivering CPS, or provide incentives (positive and/or negative) to increase patient demand for CPS (generated by patient education efforts).

Providers should be actively involved in adopting appropriate clinical guidelines, administrative rules, and quality-improvement efforts for improving CPS delivery. Providers are more likely to become actively involved in prevention activities if they are also active participants in the change process.

Medical personnel in training programs at MTF/DTFs should be trained in:

1. TRICARE and MHS
2. PPIP
3. HEAR
4. Primary care manager role and its impact on resource utilization
5. Prevention aspects of specific performance measurement tools, DoD report card, HEDIS, and JCAHO.
6. Quality approach and evidence-based practice management
7. Patient education and counseling skills
8. Marketing and customer satisfaction

MTF/DTF STAFF TRAINING

Focused skills training on the PPIP program and using PPIP materials should be locally developed and targeted to providers, nurses, technicians, clerical staff, medical records personnel, volunteers, and others who have contact with patients.

In-depth training for providers and support staff in clinical and occupational preventive strategies and tactical applications should be continuous. This training can be accomplished in grand rounds, professional staff meetings, journal clubs, and local CME/CEU meetings. Personnel should have a working knowledge of the *Clinician's Handbook of Clinical Preventive Services*, the *Guide to Clinical Preventive Services*, and the TRICARE region self-care book.

The Prevention Committee should be trained locally in assessing program cost-effectiveness and performing a cost/benefit analysis. There are nine basic steps to a cost-effectiveness analysis:

1. Frame the problem to be analyzed
2. Identify options to be compared
3. Identify outcome measures
4. Identify intervention and outcome costs
5. Construct a decision tree
6. Identify probabilities

7. Analyze the decision tree
8. Perform sensitivity analysis
9. Present the results

Health-related benefits to be considered include increased life expectancy, decreased morbidity, reduced disability, improved quality of life, averted medical costs, and increased worker productivity. Non-health (e.g., improved environmental quality) and intangible (e.g., pain and suffering) outcomes may be critical to the analysis.

Additional Training Opportunities. Additional PPIP continuing education can be accomplished during hospital newcomers' orientation, department in-service, staff meetings, etc.

PATIENT EDUCATION

Implementing PPIP requires patient education. Patients must expect wellness care as part of their medical appointments. Some reasons patients do not expect wellness care:

- They do not necessarily understand preventive medicine.
- Many do not want to hear about preventive medicine because they already have heard it many times.
- Often they do not follow preventive service recommendations, so preventive approaches may meet a dead end.

Patients must be educated to seek out preventive services. These services can be provided through the medical system. If they want and request them, patients are more likely to receive these services and become active participants in their care. They should be encouraged to seek preventive services before they become ill. A team or primary care provider approach is necessary, so that the patient knows who is responsible for various aspects of preventive care. Preventive care must also be tracked for each patient.

Patient perceptions and needs for preventive interventions must also be addressed. Specific behavioral interventions can then be tailored to the specific stage of acceptance. For example, if the provider assesses a smoker's readiness for change with a few questions, he or she can determine the appropriate intervention: a tobacco cessation program, a discussion about quitting, or simply giving the patient a pamphlet on cessation.

Many different approaches to patient education are available. Several MTFs/DTFs and clinics have kiosks available in their main lobbies. By touching the kiosk's computer screen, patients can find health promotion or education information. This educational method has proven to be very valuable.

The lack of communication and continuity between systems is an education problem. If prevention programs were standardized, a person could travel from base to base and receive the

same types of information. They would not get conflicting messages. However, because this is not yet a reality, ongoing patient education at each contact point is necessary.

In conjunction with the health-promotion program, community and/or beneficiary education **programs should address, as a minimum** the following program components:

1. Self-care
2. Personal health practices (proper nutrition, fitness, tobacco use, mental health, alcohol and drug use, heart disease and cancer prevention)
3. Youth and family violence
4. Substance abuse
5. Sexual behaviors
6. Injury prevention
7. Home safety

Other Educational Opportunities for PPIP education **for TRICARE Prime patients may be accomplished through informational handouts** and video presentations in waiting areas, articles in base and local newspapers, presentations at various installation and community meetings, radio and TV spots, and referrals to health educators. Additional opportunities exist for community education by using established orientation programs, such as the base newcomers' orientation.

HEALTH ENROLLMENT ASSESSMENT REVIEW (HEAR)

POLICY: All military hospitals and clinics must administer the age appropriate HEAR (Health Enrollment Assessment Review) annually to all TRICARE PRIME (including Active Duty) beneficiaries.

The HEAR is a self-reported health assessment tool that indicates:

- An individual's health risk factors and preventive care needs, which are reported to both the individual and their primary care manager (PCM).
- Those individuals who are likely to use high levels of medical resources.
- The appropriate training and expertise level suggested for the effective management of an individual's health care.
- Risk factors, demographics, care levels, and utilization for strategic planning in population health management and resource utilization at the MTF/DTF and Regional levels.

A copy of the HEAR questionnaire is available for reference in Appendix D.

The HEAR questionnaire survey is administered to those 17 years old and older who enroll in TRICARE Prime, and it takes about 20 minutes to complete. The survey questions cover demographics, physical activity, men's health, cholesterol status, alcohol use, mental health, activity limitations, life satisfaction/family conflict, blood pressure status, women's health, tobacco use, preventive issues, stress, absenteeism, medical care history, and chronic conditions.

Elements from the HEAR survey are computer scanned and entered into a database, either by the TRICARE contractor or local MTF. Algorithms are run against the data and several reports are generated:

1. Patient Report Card
    - A concise report addressing the individual's health risk factors, currency for recommended preventive services, and chronic disease history.
2. Primary Care Manager (PCM) Report
    - Provides the same information as the Patient Report Card, plus an assessment of the selected risk factors, predictions for resource utilization, suggested care level, and any missing or incomplete information from the HEAR survey.
        - Within 30 days of MTF receipt, the PCM team should review the PCM Report and set clinical triage protocols that match acuity. A date stamp mechanism should be established to log the date the MTF received the PCM Report.
            - Reports reflecting high resource utilization and high primary care level should be reviewed by the PCM to determine the need for further follow-up.
            - Reports reflecting moderate resource utilization and moderate primary care level should be reviewed by a nurse to determine additional follow-up, per MTF/DTF protocol.
            - Reports reflecting low resource utilization and low primary care level can be reviewed by qualified medical personnel to determine additional follow-up, per MTF/DTF protocol.

3. PCM Panel Report
    - Gives a comprehensive picture of the individuals on each PCM's panel. It identifies the number of smokers, hypertensive individuals, diabetics, individuals needing tetanus immunization, etc., by PCM.
4. Ad Hoc Custom Reports
    - Ad hoc custom reports can be generated for health promotion coordinators, PCMs, Commanding Officers or Officers in Charge, and health care planners at all levels, to support the unique objectives of an organization.
5. For further information on methods of reading aggregate data, contact your Lead Agent.

IMMUNIZATIONS

POLICY: All MTFs must implement aggressive campaigns to screen immunization status at every visit and provide age appropriate immunization services due to all infants, children, adolescents, and adults. Priority should be to identify and eliminate missed opportunities to provide immunizations. Your Prevention Committee is an essential component to this process.

The various recommendations for immunizing infants, children and adults against diseases are based on medical knowledge, the availability of safe vaccines, other scientific knowledge, and on judgments by public health officials and doctors. Each vaccine has benefits and risks associated with its use, and no vaccine is completely safe or completely effective. Vaccines are beneficial because they prevent disease infection and the various results of that disease, which may be mild symptoms such as a body rash, or more serious problems such as paralysis or death. Depending on the vaccine, the benefits may vary from partial protection to complete protection against the disease or its effects.

Immunization is one of the most effective ways to prevent disease. The widespread use of vaccines has reduced the peak-level incidence of many diseases in the United States by at least 95%. Most vaccines protect 90% or more of the individuals vaccinated. In addition, most vaccines when used widely in communities indirectly protect other persons as well, including those too young for vaccination and those with legitimate medical contraindications to vaccination.

Because immunizing children has proven to be so effective at preventing disease, immunizations against specific disease are required by all 50 states and the District of Columbia for children entering day care and/or school. It is national health policy, and one of the top five priorities of the Department of Health and Human Services (HHS), to immunize 90% of America's two-year olds by the year 2000. The Centers for Disease Control and Prevention (CDC) has developed a Recommended Childhood Immunization Schedule and is available in Appendix E. Also available in Appendix E is a Child Immunization Flow Sheet and a immunization reminder postcard, that are potential resources for your use.

Despite the generally favorable attitudes of physicians toward vaccines for adults and evidence that vaccines are cost-effective, adult immunization is not widespread. Influenza, pneumococcal, and hepatitis B vaccines are especially underused.

BUMEDINST 6230.15 of 01 NOV 95 Immunizations and Chemoprophylaxis provides the directive requirements for the Armed Forces Immunizations Program, establishes general principles, procedures, policies, and responsibilities for the immunizations program. This policy applies to the Air Force, Army, Navy, Marine Corps, and Coast Guard (Active and Reserve), nonmilitary persons under military jurisdiction, selected Federal employees, and family members eligible for care within the military health care system.

BUMEDNOTE 6230 of 20 APR 98 Immunization Requirements and Recommendations is the New BUMED NOTE ON IMMUNIZATIONS! This note augments the immunization

instruction listed above. It is available from the BUMED Home Page of http://support1.med.navy.mil/bumed/instruct/external/6230.pdf in an Adobe Acrobat® Reader file. This file can also be accessed from the Navy Environmental Health Center (NEHC), Preventive Medicine's Immunization Home Page which offers more immunization information, messages, and instructions. Their Internet address is http://www-nehc.med.navy.mil/prevmed/immun/imunmain.htm.

The *Clinician's Handbook of Clinical Preventive Services*, the *Guide to Clinical Preventive Services*, are excellent source to use for immunization information.

A successful immunization program requires an aggressive campaign to screen immunization status at every visit. There are several PPIP materials to assist with your immunization campaign. The *Personal Health Guide* and the *Child Health Guide* play a critical role in tracking and prompting an individuals' own preventive care. Studies have shown that both clinicians and patients appreciate patient-held (or parent-held) records, such as those promoting childhood immunization programs. These guides are discuss in the "Essential Resources" section of this manual.

Posters to promote and encourage immunizations are also available. They are "Waiting Room" and "Preventive Care Timeline" posters—child and adult versions (set of three for $8.00; any five for $10.00) available from the AHCPR Publications Clearinghouse. Call them at: 1-800-358-9295 or write to:

AHCPR Publications Clearinghouse
P.O. Box 8547
Silver Spring, MD 20907

Clinic Assessment Software Application (CASA) is another tool that may assist you with your immunization screening campaign. CASA is a menu-driven relational database developed by the National Immunization Program (NIP), Centers for Disease Control and Prevention (CDC), as an assessment tool for immunization clinics and providers . This application is used for the data entry and analysis components of a clinic assessment and includes reminder and recall tracking capabilities as well as many other special features. CASA is used in the conduct of a practice-based vaccination assessment and will help providers understand current vaccination coverage levels and immunization practices in the specified facility being assessed. CASA provides an extensive body of data that can be accessed and organized to suit individual practice needs. CASA produces reports from a menu and provides programmatic feedback that includes, yet is not limited to:

- Highlighting areas that may lower levels of immunization coverage.
- Up-to-date status of the defined age group served by the clinic or practice
- Up-to-date status of children at critical age markers
- Antigen-specific levels
- Proportion of children who drop out of the vaccination schedule.
- Extent of missed opportunities.
- Reminder and recall letters and postcards.

CASA software is available from the CASA website at NIP: http://www.cdc.gov/nip/casa. Those commands that do not have Internet access may

1. Call the NIP Assessment Branch at (404) 639-8392
2. Send a FAX request to (404) 639-8613
3. Send an e-mail request to: NIPINFO@CDC.GOV
4. Write to:

   The CASA Support Team
   Data Management Division
   Mail Stop E-62
   National Immunization Program
   Centers for Disease Control and Prevention
   1600 Clifton Road
   Atlanta, GA 30333

CLINICAL PREVENTIVE SCREENINGS

POLICY: Military hospitals and clinics must ensure age and sex appropriate clinical preventive screenings and other services are provided through the TRICARE PRIME Clinical Services Benefit. Prevention and health promotion counseling shall be provided and documented at every medical and dental patient encounter, particularly in primary care settings, acute care, and emergency rooms. The Guide to Clinical Preventive Services is a valuable source to determine age and sex appropriate clinical preventive screenings. The Prevention Committee may address clinical preventive screenings as part of population based evidence for your particular command.

OUTCOME OBJECTIVES REQUIRED FROM POLICY:

1. Risk assessment and counseling available for TRICARE Prime enrollees. Summary population report available for all enrollees with completed risk assessments.

CLINICAL OUTCOME OBJECTIVES: to be measured as an initial baseline, and after a 12 month initial implementation phase. After the initial 12 month evaluation, the criteria will increase to at least 20% above baseline or at least 90% . The following criteria will be used:

1. Screening for **alcohol use** baseline.
2. Screening for alcohol use increased from baseline to at least 10% above baseline for at least 60%.
3. Screening for potential heavy alcohol use baseline.
4. Screening for potential heavy alcohol use increased from baseline to at least 10% above baseline or at least 60%.
5. **Cholesterol screening** for baseline.
6. Cholesterol screening increased from baseline to a least 10% above baseline or at least 60%.
7. **Immunizations** baseline for children by age two.
8. Immunizations for children ate age two increased from baseline by at least 10% or at least 75%.
9. **Influenza immunization** baseline established for active duty personnel.
10. Influenza immunizations increased from baseline by at least 10% or at least 75%.
11. **Mammogram screening** baseline rate established for women, ages 50-69.
12. Mammogram screen rates increased above baseline by at least 10% or at least 60%.
13. **Pap smear** baseline established for women 21 to 64.
14. Pap smear rates increased above baseline by at least 10% or at least 60%.
15. **Tobacco use** screening baseline.
16. Tobacco use screening increased above baseline by at least 10% or at least 60%.

Examples of Important Preventive Services Addressed by *Guide to Clinical Preventive Services* follows.

Examples of Preventive Services Recommended for Routine Use

Screening for Colorectal Cancer

Condition: Colorectal cancer causes 55,000 deaths each year and is the second most common form of cancer in the U.S.

1995 Recommendation: Screening for colorectal cancer is recommended for all persons aged 50 and older, using sigmoidoscopy, annual fecal occult blood testing, or both. The optimal interval between sigmoidoscopic examinations is not established; a 10-year interval may be adequate.

Counseling To Prevent Tobacco Use

Condition: Tobacco use causes one of every five deaths in the U.S. each year, making it the most important preventable cause of premature death.

1995 Recommendation: Periodic counseling to stop tobacco use is recommended for all persons who use tobacco. Delivering anti-tobacco messages is recommended as part of health promotion counseling for children, adolescents, and young adults. The prescription of nicotine patches or gum is recommended as an adjunct to counseling to help selected patients quit tobacco use.

Screening for Breast Cancer

Condition: Breast cancer is the leading cause of cancer in women, accounting for 46,000 deaths annually.

1995 Recommendation: Screening for breast cancer with mammography every 1 or 2 years (with or without annual clinical breast examination) is recommended for all women ages 50 to 69 years of age. There is insufficient evidence to recommend for or against routine mammography or clinical breast examination for women aged less than 50 years or 70 years and older.
Counseling To Prevent Injuries

Condition: Unintentional injuries account for about 89,000 deaths, 2.7 million hospitalizations, and 34 million emergency department visits each year, resulting in a lifetime economic cost of $182 billion. Almost half of unintentional injury deaths are due to motor vehicle crashes; the remainder are due to household, recreational, and other unintentional injuries.

1995 Recommendation: All patients should be counseled to use lap/shoulder belts and child safety seats (as appropriate for age) and to wear safety helmets when riding motorcycles. Adolescents and adults should refrain from driving or engaging in potentially dangerous activities such as swimming, boating, bicycling, or hunting while under the influence of alcohol or other drugs. Parents of young children should be counseled on measures to reduce the risk of unintentional household and recreational injuries, and such counseling may also be beneficial for

adult patients. Examples of recommended preventive measures include smoke detectors, bicycle helmets, swimming pool isolation fences, and the safe storage or removal of firearms from the home.

Example of Preventive Service Recommended for Targeted Use

Screening for High Blood Cholesterol and Other Lipid Abnormalities

Condition: Elevated blood cholesterol is one of the major modifiable risk factors for coronary heart disease, which is the leading cause of death in the U.S.

1995 Recommendation: Periodic screening for high blood cholesterol is recommended for all men ages 35-65 and women ages 45-65. Screening may be recommended on other grounds for healthy persons ages 65-75, adolescents, and young adults, when they have major coronary risk factors (smoking, hypertension, diabetes). Recommendations against routinely screening children may be made based on potential risks and costs. There is insufficient evidence to recommend for or against routine screening for other lipid abnormalities.

Examples of Preventive Services Not Recommended for Routine Use

Screening for Prostate Cancer

Condition: Prostate cancer causes 40,000 deaths in the U.S. each year. Many older men, however, harbor small, slow-growing prostate cancers that will not cause significant symptoms during their lifetime.

1995 Recommendation: Routine screening for prostate cancer by measurement of prostate-specific antigen (PSA) or performance of digital rectal examination (DRE) is not recommended.

Intrapartum Electronic Fetal Monitoring

Condition: Abnormal fetal heart rate and other early signs of fetal distress, reported in 4% of pregnancies, may be detectable by electronic fetal monitoring (EFM). These abnormalities may indicate lack of oxygen to the fetus. Severe lack of oxygen (asphyxia) causes a total of 700 stillbirths and neonatal deaths each year. The use of EFM doubles the likelihood of having a cesarean delivery.

1995 Recommendation: Routine electronic fetal monitoring is not recommended for low-risk women in labor when adequate clinical monitoring by trained staff is available. There is insufficient evidence to recommend for or against intrapartum EFM over clinical monitoring in high-risk pregnancies.

DOCUMENTATION

POLICY: All MTFs and DTFs must document in medical and dental records, clinical preventive services (CPS) and prevention or health promotion counseling provided to MHS TRICARE Prime beneficiaries. The MHS prevention flowsheet, DD Form 2766, must be used in every outpatient medical record for TRICARE PRIME beneficiaries to flowchart CPS. Services provided must also be documented on the SF600. Providers using the SOAP (subjective-objective-assessment-plan) note format are encouraged to add an extra "P" for prevention to document prevention and wellness issues. Emphasis should be placed on query and documentation of immunization status and use of tobacco and alcohol.

PROCESS OUTCOMES REQUIRED FROM POLICY:

1. DD Form 2766, Adult Preventive and Chronic Care Flowsheet, used in at least 75% of TRICARE Prime medical records.
2. PPIP counseling documented on SF600 in at least 75% of TRICARE Prime medical records.
3. SOAP-P medical record format used in at least 75% of TRICARE Prime medical records.

DD FORM 2766, ADULT PREVENTIVE AND CHRONIC CARE FLOWSHEET

DD Form 2766 was developed as a Tri-Service form and will be used by all DoD military personnel and TRICARE Prime beneficiaries to ensure continuity of care in the TRICARE system and during deployment.

As of June, 1998, DD Form 2766 may be used as a preventive care flow sheet in all Navy medical records for adults. This form will be mandatory for all MTFs by in April 1999. A copy of this form is available in Appendix F.

GENERAL INSTRUCTIONS

This instructional tool clarifies documentation for the DD Form 2766, *Adult Preventive and Chronic Care Flowsheet.* It explains the organization of the form and outlines methods of incorporating this form into the Navy Medical System. [Special Note: DD Form 2766 replaces AF Form 1480A and DD Form 2766c replaced AF Form 1480B. All AF Form 1480's are grandfathered and do not require reaccomplishment to the DD Form 2766 except when the six-year life expectancy is completed or there is a need to reaccomplish it due to loss or mutilation.]

The **priority** of the populations who will receive the DD Form 2766 on their medical records are as follows: Active Duty and TRICARE Prime adult beneficiaries. This form should be placed on the top left side of the first cover in the record.

A flowsheet for Childhood Preventive Care and Childhood Immunizations is being separately developed.

Transcription
DD Form 2766 replaces the Summary of Care NAVMED 6150/20 (Rev. 1-94), Immunization Record for Adults, SF 601, and any local flow sheets used to track clinical preventive services. All information documented on the medical record is considered a part of the legal document and will not be discarded from the medical record at any time. After information is transcribed from the existing forms (as listed above) draw a line diagonal line through the form and the word "Transcribed" will be written along the line with the date, full name, rank and navy specialty code of the transcribing individual. All forms transcribed will remain with the medical record and placed behind the new DD Form 2766 and the Health Enrollment Assessment Review for Primary Care Managers (HEAR PCM Report). The correct order of forms behind the DD Form 2766 is:

- DD Form 2766c (supplemental continuation sheet)
- Summary of Care, NAVMED 6150/20 (REV. 1-94)
- Immunization Record for Adults, SF 601
- Other local flow sheets used to track preventive services

Priority for transcription can be accomplished on a first come, first transcribed basis. Transcribe records as patients present themselves to clinic. There is no need to attempt to transcribe all records immediately.

Use of DD Form 2766 by non-active duty TRICARE Prime beneficiaries.

- All non-active duty TRICARE Prime beneficiaries should use pages 1 of 4 and 2 of 4. Pages 3 of 4 and 4 of 4 are not required, since they pertain to readiness issues. The automated printout from the immunization tracking system should be used to document the patient's immunizations. All other non-active duty beneficiaries not enrolled in TRICARE Prime may use DD Form 2766 at the discretion of the provider or individual Services.

DD Form 2766 is designed to track those CPS reported in the *Guide to Clinical Preventive Services* (2nd ed.); the TRICARE Prime Benefit package; the Advisory Committee on Immunization Practices; and BUMEDINST 6230.15 of 01 NOV 95 - Subj: Immunizations and Chemoprophylaxis. The BUMED instruction provides the directive requirements for the Armed Forces Immunizations Program, establishes general principles, procedures, policies, and responsibilities for the immunizations program. This policy applies to the departments of the Air Force, Army, Navy, Marine Corps, and Coast Guard (Active and Reserve), nonmilitary persons under military jurisdiction, selected Federal employees, and family members eligible for care within the military health care system.

The additional blank boxes in specific prevention areas should be reserved for future Navy or DoD requirements. MTF/DTF-specific prevention items should be documented on DD Form 2766c, **Adult Prevention and Chronic Care Flowsheet – Continuation Sheet**.

All documentation will be completed in ink, except in Section 1, "Allergies"; Section 3, "Medications"; Section 7, "Screening Exams"; and glasses prescription in Section 10 "Readiness." See Sections 1, 3, 7, and 10 for an explanation.

DD Form 2766c, **Adult Preventive and Chronic Care Flowsheet - Continuation Sheet**

- DD Form 2766c is a continuation form for DD Form 2766, or it may be used for local requirements. For active duty personnel, attach it to the bracket on page 2 of 4 of DD Form 2766 when it is completed. For TRICARE Prime beneficiaries, place it behind DD Form 2766.
- DD Form 2766c is authorized for local reproduction.

IMPLEMENTING DD FORM 2766 IN THE MTF

Every MTF has unique organizational challenges (staffing, space, flow, etc.) in completing DD Form 2766. Each MTF should establish protocols indicating which individuals or departments are responsible for specific sections of the DD Form 2766. Suggested ways of completing the form:

- Sections 1, 2, and 3 ("Allergies," "Chronic Illness," and "Medications"): by the provider.
- Section 4 ("Hospitalizations/Surgeries"): by medical personnel during the screening process, as the patient checks into the clinic.
- Section 5 ("Counseling"): by the medical personnel who provide the counseling
- Section 6 ("Family History"): by those medical personnel responsible for discussing family medical history.
- Section 7 ("Screening Exams"): by those medical personnel ordering the exam or reviewing the results. Qualified administrative personnel may document results in the DD Form 2766 prior to review by medical personnel.
- Section 9 ("Immunizations"): by the immunization clinic attaching the automated DD Form 2766c immunization form (or other automated immunization form) to the DD Form 2766 for active duty personnel, and behind the DD Form 2766 for non-active duty beneficiaries.
- Sections 8, 10, and 11 ("Occupational History/Risk," "Readiness," and "Pre/Post Deployment History"): before and after deployment.

A *Patient Routing Slip Instructions* has been developed by a Navy Command to optimize the flow of patients through Family Practice Clinic appointments. A copy of this slip, with instructions, is included in Appendix G for adaptation into your command.

DOCUMENTATION

Section 1, "Allergies":

- Write the medication and other types of allergies within the area noted.
- If patient does not have any allergies, write "N/A" in pencil.

Section 2, "Chronic Illness": List chronic illnesses.

Section 3, “Medications”:

- You may complete this section in pencil.
- List current medications, including dosage, frequency, and purpose (e.g., “Inderal LA - hypertension versus migraine control”).

Section 4, “Hospitalizations/Surgeries”: List hospitalizations and all surgeries, including dates.

Section 5, “Counseling”:

- Fill in “Date,” “Age,” and “Topic” at the annual prevention assessment (e.g., TRICARE Prime enrollment or when the HEAR is evaluated and the patient is counseled). Counseling is listed from the general to the specific. Write the letter associated with the type of counseling in the corresponding box (e.g., “F” for fitness). When all preventive health topics are addressed, you may write “all areas addressed” in the block. Circle the letter that corresponds to the individual’s high-risk profile. There are extra boxes for documenting “outstanding” high-risk preventive counseling (e.g. alcohol abuse, mental health concerns, etc.) accomplished at times other than the annual assessment.
- Document preventive counseling on SF 600, **Chronological Record of Medical Care**, at every visit using the **SOAPP format** (where the second “P” is for prevention counseling). The counseling block on DD Form 2766 does not take the place of **quality counseling** documentation on SF 600, nor is it assumed to be an official referral for further education from community-based services.
- “Advanced Directives” (Living Will) – Place Advanced Directives (Self-Determination Act forms) in an envelope and file them in section 4 of the folder, as the last document. Annotate the DD Form 2766 to indicate that a living will is filed and the date it was filed.

Section 6, “Family History”:

- In the larger block, fill in the family member’s designation with the corresponding disease, using the key provided.
- Specify the types of illness or disease.
- Document the age of the family member at the time of death, particularly if there is a correlation between the illness or disease process.

Section 7, “Screening Exams”:

- Exams are listed from the general to the specific. Fill in the current year and patient’s age in the first block of the frequency field, and continue out for six years.
- Fill in the circles under the “Date” and “Age” fields to denote the next time the screening exam is due.
- Documenting screening exams:
  - Use pencil for the date the exam is ordered.
  - Use ink when the exam is completed, and the results have been received and reviewed.
  - Use the proper key code, or write in the actual results in the blocks.

– Update each flowsheet every time preventive care is ordered, performed, or results are returned.

Section 8, "Occupational History": Check the appropriate box and list the exposure hazards, as needed.

Section 9, "Immunizations":

- You must record the date and type of immunization. You will document titers with the date and result, using the corresponding date block.
- Additional blank data blocks allow for flexibility, in case an injection or titer is required that is not presently listed.
- You must document lot numbers in the medical record. You may fill in the date block by hand, stamp, sticker, or automation, to comply with national regulations.
- If you document the date and lot number in the medical record, it does not have to be duplicated on DD Form 2766.
- Additional resources should be considered to accomplish this labor-intensive task. MTFs may also use bar-coding to log the lot information into their automated system.

Section 10, "Readiness":

- Enter date and required information in the appropriate spaces.
- Write the optometry prescription directly below the "Glasses/Gas Mask" block description. You may document changes in the prescription within the date block, as needed. Pencil may be used in this section to document the prescription.

Section 11, "Deployment":

- Document deployment location and completion dates of pre- and post-deployment evaluations here. If needed, continue the deployment-history documentation on DD Form 2766c.
- Until DD Form 2766 is initiated, documenting deployments is not required.
- Place documentation of pre- and post-deployment evaluations for classified operations in the individual's personnel folder.

CHART AUDIT

This action is reserved for official JCAHO and military inspections. MTFs may use this area for test surveys in preparation for official inspections. Place the date in the designated square.

SF 600, HEALTH RECORD: CHRONOLOGICAL RECORD OF MEDICAL CARE

Every patient encounter using SF 600 should contain prevention documentation. The DD Form 2766 counseling block does not take the place of quality counseling documentation on the SF 600. Document health and wellness, preventive counseling, referrals, and prescriptions on SF 600, using the "SOAPP" note format (where the second "P" indicates prevention documentation).

MONITORING AND EVALUATION

POLICY: Prevention and health promotion performance measurements as required by the MHS shall be accomplished through evaluation instruments such as HEDIS, HEAR, the DoD Annual Beneficiary Survey, and the tri-annual DoD Survey of Health Related Behaviors Among Military Personnel. **The PPIP Coordinator identifies and implements both process and outcome evaluation activities as part of the BUMED instruction and MHS Plan as well as develops the PPIP Implementation Plan.** Process and outcome measurements for implementing PPIP in all MTFs (and DTFs, when applicable) that must be implemented by April 1999 follow: (NOTE, all of these outcomes have been stated throughout this manual, in related sections, to guide your implementation process)

PROCESS OUTCOMES

Process Outcomes must begin to be measured 6 months after initial implementation phase of PPIP, to include:

a. Prevention Committee established, and members designated in writing.
b. PPIP coordinator appointed, in writing.
c. PPIP local plan completed.
d. DoD Form to track clinical preventive services (adults), is used in at least 75% of TRICARE Prime medical records.
e. PPIP counseling documented on SF 600 in at least 75% of TRICARE Prime enrollees records.
f. SOAP-P, with this added P for Prevention Prescription, is the documentation format used by Health Care Providers, in at least 75% of TRICARE Prime medical records.
g. Performance feedback to providers monthly.
h. PPIP training completed for 75% of primary care staff.
i. PPIP education materials provided to 75% of TRICARE Prime patients seen at medical facility.
j. PPIP coordinator has dedicated computer Internet access.
k. PPIP clinician's handbooks are provided to 75% of primary care staff.
l. Risk assessment and counseling available for TRICARE Prime enrollees. Summary population reports available for all enrollees with completed risk assessment.
m. Risk assessment and counseling available for TRICARE Prime enrollees. Summary population reports available for each worksite.

CLINICAL OUTCOME OBJECTIVES

Clinical Outcome Objectives to be measured as an initial baseline, and after a 12 month initial implementation phase. After the initial 12 month evaluation, the criteria will increase to at least 20% above baseline or a least 90% . The following criteria will be used:

a. Screening for alcohol use baseline.
b. Screening for alcohol use increased from baseline to at least 10% above baseline for at least 60%.
c. Screening for potential heavy alcohol use baseline.
d. Screening for potential heavy alcohol use increased from baseline to at least 10% above baseline or at least 60%.

e. Cholesterol screening for baseline.
f. Cholesterol screening increased from baseline to a least 10% above baseline or at least 60%.

g. Immunizations baseline for children by age two.
h. Immunizations for children ate age two increased from baseline by at least 10% or at least 75%.
i. Influenza immunization baseline established for active duty personnel.
j. Influenza immunizations increased from baseline by at least 10% or at least 75%.

k. Mammogram screening baseline rate established for women, ages 50-69.
l. Mammogram screen rates increased above baseline by at least 10% or at least 60%.

m. Pap smear baseline established for women 21 to 64.
n. Pap smear rates increased above baseline by at least 10% or at least 60%.

o. Tobacco use screening baseline.
p. Tobacco use screening increased above baseline by at least 10% or at least 60%.

ESSENTIAL RESOURCES

1998 CLINICIAN'S HANDBOOK OF PREVENTIVE SERVICES

POLICY: DoD and BUMED Policy requires this publication be provided to all providers and support staff members in primary care settings at medical treatment facilities (MTFs).

PROCESS OUTCOME REQUIRE FROM POLICY

1. Clinician's Handbook provided to 75% of primary care staff.

The Clinician's Handbook of Preventive Services is part of a set of materials created for the U.S. Public Health Services' Put Prevention into Practice campaign. The Handbook is designed to provide primary care clinicians with a practical and comprehensive reference on clinical preventive services, screening tests for the early detection of disease, immunizations and prophylaxis to prevent disease, and counseling to modify risk factors that lead to disease.

A user-friendly manual in two large sections - children/adolescents and adults/older adults. For each of these large sections there is a component for screening, immunization/prophylaxis, and counseling. Each of the 62 chapters includes basic steps of performing the service, a description of the burden of suffering from the target condition, the recommendations of major authorities, and listings of patient and provider resources. This manual is designed for use both by practicing clinicians and students. Of great interest to all is the Overview section IV, Implementing Preventive Care. This chapter presents practical instructions for implementing a system for delivering preventive care services. These instructions will facilitate putting prevention into your practice.

The Virtual Hospital (developed by the University of Iowa) now offers an on-line version of PPIP's Clinician's Handbook. This site features the full text of the publication including all sixty chapters and graphs/charts. You can view Virtual Hospital's Clinician's Handbook by going to: http://vh.radiology.uiowa.edu/Providers/ClinGuide/PreventionPractice/TableOfContents.html.

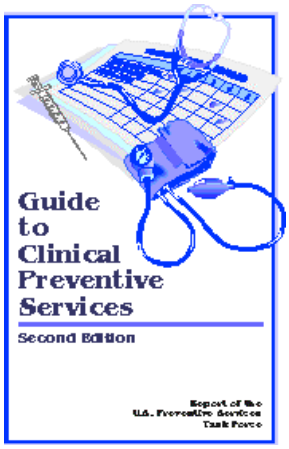
Ordering information:

HHS AHCPR Clearinghouse
http://www.ahcpr.gov/ppip/pporder.htm
P.O. Box 8547
Silver Spring, MD 20907
Phone: (800) 358-9295

OPTUM (contact JW. Hornsby)
(703) 394-7615
e-mail : jhornsb@uhc.com

International Medical Publishing, Inc.
ISBN 1-883205-32-8
Phone: (703) 519-0807
http://www.intlmedpub.com

GUIDE TO CLINICAL PREVENTIVE SERVICES, U.S. PREVENTIVE SERVICES (USPSTF) TASK FORCE



A task force of prominent preventive health specialists recommend that doctors and nurses offer more frequent patient counseling on personal health and safety habits, significantly change the use of some screening tests, and ensure that several newer immunizations are routinely provided. The U.S. Preventive Services Task Force, an independent panel first convened in 1984 as an initiative of the U.S. Public Health Service, issued the first revision of its widely used 1989 guide to effective disease prevention and health promotion, based on a careful review of scientific evidence.

Many of the recommended changes in the Guide to Clinical Preventive Services, 2nd Edition reflect new evidence about important health benefits of selected preventive services. Other changes reflect a more critical look at the balance of harms and benefits of screening tests now in wide use. The report also reaffirms many of the disease and injury prevention practices recommended in 1989. The guide is intended to supplement the *Clinician's Handbook of Preventive Services*.

Ordering information:

Superintendent of Documents
U.S. Government Printing Office
(202) 512-1800
Stock No. is 017001005258
single copy price is $35 (shipping included)

International Medical Publishing, Inc.
ISBN 1-883205-32-8
Phone: (703) 519-0807
http://www.intlmedpub.com

Williams & Wilkins
(800) 358-3583

OPTUM (contact JW. Hornsby)
(703) 394-7615
e-mail : jhornsb@uhc.com

The Guide is also available to view online at:
http://odphp.osophs.dhhs.gov/pubs/guidecps/pcpstoc.htm

PERSONAL HEALTH GUIDE AND CHILD HEALTH GUIDE

These two pocket sized booklets offer a brief explanation of prevention topics and risk factors - such as weight, blood pressure, immunizations, physical activity, and family planning - and enable the consumer (or parent) to actively participate in preventive care. Easy-to-use record forms in each booklet help clinicians monitor and consumers prompt needed preventive care. The Personal Health Guide is available in two versions: the white-cover booklet uses the term "doctor" throughout, and the green-cover booklet uses the term "clinician." Spanish translations of the Personal Health Guide are currently in development. The Personal Health Guide and Child Health Guide are both designed to be flexible and support any regimen of preventive services specified by the provider. They are passport sized.

This, from Consumer Information Center, Pueblo, CO 81009:

"The Personal Health Guide (Item 121B, $1.00) lists examinations you should have regularly and includes a chart to keep track of your weight, blood pressure, cholesterol, immunizations, medications, and the dates and results of your examinations after each checkup. The publication also features a directory of selected toll free numbers for information about health and safety.

There's nothing worse than seeing your children's sad eyes when they aren't feeling well. The Child Health Guide (102B, $1.00) tells what preventive care your children need to stay well and how to work with their doctors to make sure they get it. The publication has a growth chart and a list of the various developmental activities your children should master as they grow from two months to five years old. It also tells you at what age and how often your children should have certain tests, and includes a directory of hotline phone numbers for information on topics such as maternal health, safety and injury prevention, and child abuse.

Take this opportunity to better your family's health and safety. Order the Personal Health Guide (Item 121B, $1.00) and the Child Health Guide (Item 102B, $1.00), by sending your name, address, item numbers, and the correct fees to R. Woods, Consumer Information Center, Pueblo, CO 81009. When you write, you'll also receive a free copy of the Consumer Information Catalog. The Consumer Information Center of the U.S. General Services Administration revises and publishes the Catalog quarterly, so you know it's up-to-date. Its pages list more than 200 free and low-cost federal publications on a wide variety of subjects. The Personal Health Guide is available for consumer purchase from the Consumer Information Center in Pueblo, CO. (on-line ordering information provided)" The Consumer Information Center in Pueblo, CO, Internet site for ordering is: http://www.pueblo.gsa.gov

The guides are also available through the HHS AHCPR Clearinghouse at: http://www.ahcpr.gov/ppip/pporder.htm. or, by calling 1-800-358-9295 or writing to:

AHCPR Publications Clearinghouse
P.O. Box 8547
Silver Spring, MD 20907

OTHER RESOURCES, REFERENCES BOOKS AND MATERIAL

HEALTH PROMOTION AND DISEASE PREVENTION IN CLINICAL PRACTICE

This book brings together the essential details for providing comprehensive, high-quality, evidence-based preventive care. Written by leading national authorities on clinical preventive care, the book provides state of the art, step by step instructions on how to put prevention into practice: what to ask about during the history, how to perform a Pap smear or thorough breast exam, how to talk to patients about smoking and other health behaviors, follow-up of abnormal screening test results, how to vaccinate, preventive services to avoid, and much more.

The book is organized by risk factors, the same as those your patients present in the clinical setting. This valuable book reviews the recommendations for the newly revised U.S. Task Force *Guide to Clinical Preventive Services* (previously reviewed) and provides step-by-step instructions on how to put prevention into your practice. You'll find in-depth examinations of common risk factors associated with

- Exercise
- Tobacco Use
- Nutrition
- Weight Control
- Sexually Transmitted Diseases
- Substance Abuse
- Injury Prevention

The highly respected editors, authors and advisors of the original *Guide* give you the tolls to practice evidence-based prevention medicine, including how to

- Gather the right information for risk assessment and preventable disease
- Design a personalized health maintenance plan by health behaviors
- Prescribe the right treatments
- Order screening tests and follow-up
- Develop health maintenance schedules

The authors also provide a complete list of patient education materials on prevention topics.

Ordering information:

1-800-358-3583
Williams & Wilkins
351 West Camden Street
Baltimore, MD 21201

GUIDELINE FOR ADOLESCENT PREVENTIVE SERVICES (GAPS)

Changes in adolescent morbidity and mortality during the past several decades have created a health crisis for today's youth. Unintended pregnancy, STDs including HIV, alcohol and drug abuse, and eating disorders are just some of the health problems faced by an increasing number of adolescents from all sectors of society. This health crisis requires a fundamental change in the emphasis of adolescent services -- a change whereby a greater number of services are directed at the primary and secondary prevention of the major health threats facing today's youth. School and community organizations have responded to the need for change by increasing health education programming. Primary care physicians and other health providers must respond by making preventive services a greater component of their clinical practice. Guidelines for Adolescent Preventive Services (GAPS) can direct providers in how to deliver these services. GAPS is a comprehensive set of recommendations that provides a framework for the organization and content of preventive health services.

To order this guide, please write to

Department of Adolescent Health
American Medical Association
515 North State Street
Chicago, Illinois 60610
ISBN: 0-89970-749-1

This guide may be viewed on the Internet at:
http://www.ama-assn.org/adolhlth/recomend/monogrf1.htm

BRIGHT FUTURES: GUIDELINES FOR HEALTH SUPERVISION OF INFANTS, CHILDREN, AND ADOLESCENTS

The Bright Futures project was sponsored by the Maternal and Child Health Bureau of the U.S. Public Health Service and the Medicaid Bureau of the Health Care Financing Administration. It represents a significant advancement in formulating expert guidance for providing health services to children and their families. More than 100 distinguished professionals, representing a wide range of child health and related perspectives, served on four expert panels and the board of directors. These professionals were charged with the mission of developing health supervision guidelines responsive to the current and emerging disease prevention and health promotion needs of infants, children and adolescents.

To realize the expert vision for health supervision, four multidisciplinary panels were convened to discuss health supervision issues for the developmental periods of infancy, early childhood, middle childhood, and adolescence. After a review of the literature and extensive dialogue, the panels drafted the *Bright Futures* guidelines based on their review of the science and on expert opinion and consensus.

The expert panels based their work on the belief that health supervision is:

- A longitudinal process that promotes a partnership and shared agenda between the health professional, the child, and the family.
- Personalized to fit the individual.
- Contextual—i.e., views the child in the context of the family and the community.
- Supportive of the child's self-esteem, sense of competence, and mastery.
- Based on a health diagnosis.
- Focused on the strengths as well as on the problems and issues of the family and community.
- Part of a seamless system that includes community based health, education, and human services.
- Complementary to health promotion and disease prevention efforts in the family, the school, the community, and the media.

Guidelines for Health Supervision of Infants, Children, and Adolescents is not copyrighted. Users are free to duplicate all or part of the information contained within. Copies of the publication are available for approximately $20 from:

National Maternal and Child Health Clearinghouse
2070 Chain Bridge Road
Suite 450
Vienna, VA 22182
(703) 821-8955
Fax: (703) 821-2098
E-mail: nmchc@circsol.com.

SMOKING CESSATION: CLINICAL PRACTICE GUIDELINE

New guideline challenges clinicians to help smokers quit.

Clinicians should aggressively help their smoking patients quit, according to a new clinical practice guideline sponsored by the Agency for Health Care Policy and Research. The guideline, developed by a panel of smoking cessation experts, challenges all clinicians, including doctors, nurses, dentists, and others, to find out if their patients smoke, repeatedly encourage them to quit, and recommend treatments proven to work.

The 19-member panel was led by Michael C. Fiore, M.D., M.P.H., Director of the University of Wisconsin's Center for Tobacco Research and Intervention, and included physicians, nurses, mental health experts, a dentist, a pharmacist, psychologists, an epidemiologist, an educator, and a consumer representative.

The panel's recommendations include using the nicotine patch or nicotine gum—which doubles the chances of successfully quitting—combined with a clinician's encouragement and support and practical advice to smokers on how to cope with situations and behaviors that make them want to smoke.

According to Douglas B. Kamerow, M.D., M.P.H., AHCPR's director of clinical practice guideline development, there are about 46 million adult smokers in the United States, and more than 70 percent of them would like to stop smoking. Dr. Kamerow calls on clinicians to approach smoking as a chronic condition that is very difficult but not impossible to treat.

This is the first time the total body of information on smoking cessation has been analyzed systematically. In developing the guideline, the panel reviewed over 3,000 scientific articles that addressed the assessment and treatment of tobacco dependence, nicotine addiction, and clinical practice.

Only half the smokers who see a doctor have ever been urged to quit. If only 100,000 physicians helped 10 percent of their patients end their addiction each year, the number of smokers in the United States would drop by an additional 2 million people annually.

Smoking is the single greatest preventable cause of illness and death in the United States. People who smoke are at increased risk of heart disease, cancer, and other smoking-related illnesses that contribute to over 420,000 deaths a year. Medical costs for smokers are $50 billion annually, with an additional $47 billion for indirect expenses, such as time lost from work and disability.

Whenever possible, smoking cessation treatments should be appropriately tailored to ethnic or racial groups. The guideline also offers recommendations for pregnant women, hospitalized patients, and persons with psychological problems. Recommendations also address tobacco prevention and cessation in children and adolescents and use of smokeless tobacco products (snuff and chewing tobacco).

No conclusions were drawn about the effectiveness of acupuncture, hypnosis, and drug therapies such as clonidine, antidepressants, and anxiolytics/benzodiazepines because of insufficient or inconclusive evidence.

The panel also made no recommendations regarding the use of nicotine nasal sprays and nicotine inhalers, since data on these products were limited. At the time of the panel's deliberations, the products were not licensed for prescription use in the United States. [As the guideline went to press, the Food and Drug Administration approved the prescription use of nicotine nasal spray.]

The guideline publications Smoking Cessation: Quick Reference Guide for Primary Care Clinicians (AHCPR Publication No. 96-0693); Smoking Cessation: Quick Reference Guide for Smoking Cessation Specialists (AHCPR Publication No. 96-0694); and You Can Quit Smoking: Guide for Consumers (AHCPR Publication No. 96-0695) are available from AHCPR.

The full guideline, Smoking Cessation: Clinical Practice Guideline No. 18, is available from the U.S. Government Printing Office (GPO stock no. 017-026-00159-0, $4.75 per copy); call the GPO order desk at 202-512-1800 for bulk price and ordering information. Bulk copies of the Quick Reference Guide for Primary Care Clinicians (GPO stock no. 017-026-00160-3; $20 per pack of 100), Quick Reference Guide for Smoking Cessation Specialists (GPO stock no. 017-026-00161-1, $16 per pack of 20), and the Consumer Guide (GPO stock no. 017-026-00158-1, $11 per pack of 20) also are available from GPO.

ADDITIONAL RESOURCES

There are many resources available for downloading from the NEHC Health Promotion Home Page under our program site of PPIP. The address is: http://www-nehc.med.navy.mil/hp/index.htm.

The following documents and links are currently available on the Home Page:

1. The Sixth Report of the Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure Guidelines.

2. DoD Policy for PPIP (PDF File).

3. MHS Plan for Implementation of Put Prevention Into Practice (PPIP) and Training Staff and Educating Beneficiaries in Health and Fitness.

4. Adult Preventive and Chronic Care Flowsheet, DD Form 2766 Mar 1998.

5. Adult Preventive and Chronic Care Flowsheet Continuation DD Form 2766C Mar 1998.

6. Guide to Clinical Preventive Services at http://odphp.osophs.dhhs.gov/pubs/guidecps.

7. Clinician's Handbook: The Virtual Hospital now offers an on-line version of PPIP's Clinician's Handbook at http://vh.radiology.uiowa.edu/Providers/ClinGuide/PreventionPractice/TableOfContents.html

8. Agency for Health Care Policy and Research (AHCPR) is responsible for the national campaign for PPIP. This site offers also offers information to obtain PPIP materials. http://www.ahcpr.gov/ppip

9. Visit the Air Force's Home Page for PPIP at http://www.ophsa.brooks.af.mil/PPIP_SC.HTM